

T H E H E A L T H

of the
RURAL DISTRICT OF
L U T T E R W O R T H

Leicestershire



1954

The ANNUAL REPORT
of the Medical Officer of Health
and the Chief Sanitary Inspector

RURAL DISTRICT OF LUTTERWORTH

ANNUAL REPORT

of the

MEDICAL OFFICER OF HEALTH

D.H. McFarland, M.B., B.Ch., B.A.O., D.P.H.,

together with the

ANNUAL REPORT


of the

CHIEF SANITARY INSPECTOR

H.G. McNaught, M.I.Mun.E., A.M.P.T.I., M.R.San.I.,

for the

YEAR 1954



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LUTTERWORTH RURAL DISTRICT COUNCIL

Public Health Committee 1954

L.G.W. Pickering. Chairman

K. Egan. Vice-Chairman

C.L. Hill, J.P. Chairman of the Council (ex-officio)

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Lt. Col. H.S. Barker, D.S.O. J.A. d'O. Reynolds.

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PUBLIC HEALTH DEPARTMENT

Officers and Staff

Medical Officer of Health:

D.H. McFarland, M.B., B.Ch., B.A.O., D.P.H.

Surveyor and Chief Sanitary Inspector:

H.G. McNaught, M.I.Mun.E., A.M.T.P.I., M.R.San.I.

Additional Sanitary Inspector:

D.L. Cunnick, A.R.San.I., M.S.I.A. (resigned 31st August 1954)

K.C. Brooke, Cert.S.I.J.B., Dip.R.I.P.H.&H., M.S.I.A.
(appointed November 1954)

Clerk (Part-Time):

Mrs. B.M. Laughton.

"Let the bold and the busy hunt glory and wealth,
All the blessing we ask is the blessing of health."

To the Chairman and Members of
Lutterworth Rural District Council.

Mr. Chairman, Lady and Gentlemen,

I have pleasure in presenting the Annual Report on the Health of the District for the year 1954.

The Vital Statistics present a satisfactory picture, with the Death Rate remaining practically static, the average Infant Mortality Rate over the last three years still decreasing, and the Birth Rate steadily falling over the post-war period.

Infectious diseases show a year without major incident, apart from a mild epidemic of dysentery, which has been described in detail. Once again, there has been a happy absence of typhoid fever, diphtheria, smallpox, and poliomyelitis. But let it be well understood that unless there is unremitting vigilance, these gains will not be maintained.

The problems of the aged with regard to housing have been gone into, and the position as I see it outlined.

In conclusion, I should like to express my appreciation of the support extended to me by the Chairman and Members of the Health Committee, and to thank all members of the Department, and, indeed, the Council staff, for their help during the year.

I am Mr. Chairman, Lady and Gentlemen,

Yours obediently,

D.H. MCFARLAND,

Medical Officer of Health.

VITAL STATISTICS

BIRTHS

Live Births	Males	Females	Total
Legitimate	100	91	191
Illegitimate	1	-	1
Totals	101	-	192

BIRTH RATE

16.0 per 1,000 estimated population

1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943
13.8	14.6	12.7	12.7	14.9	15.0	14.9	14.9	14.1	16.4	19.3

1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954
21.1	17.9	20.0	21.6	20.5	17.9	17.9	17.0	16.2	16.6	16.0

The birth rate of 16.0 per 1,000 estimated population is lower than last year and represents part of a gradual fall during the post-war period, indeed, since 1942.

Probably one of the biggest factors responsible for this falling birth rate is the more wide spread knowledge of family planning. Parents endeavour, chiefly through economic necessity, to limit their family so that every child shall have the maximum opportunity for health and happiness. The family can plan its future so that each member will enjoy the greatest possible mental and physical benefit, and the maximum opportunity for survival. This subject of family planning is fraught with religious and ethical implications and will now be smartly dropped.

Some other factors on which the birth rate depends are :- the proportion of women who do in fact marry: the desire of married couples to have children: the ability of married couples to have children, and the number of women who can marry, (i.e. find a mate in a monogamous society in which there are more women than men).

Considering the age at which people marry, one has only to recall the fashionable age of marriage in our grandfathers' and grandmothers' time and consider it with today. There seems to be a definite shift from the before-twenty year stage to the middle-twenty, and even later-twenty year stage. Indeed, going back further, the greatest love romances of history occurred between men and women whom we in the twentieth century now regard as having not yet reached years of maturity. Most of these great lovers of romance had not yet attained the present age of consent, and, nowadays, they would be treated as juvenile delinquents and sent to an approved school. Achilles' love affair with Deidamia, by which

a son was born to him, happened when he was only fourteen. Juliet was of the same age when Romeo fell in love with her. Helen was married at the age of twelve, Daphnis was fifteen, and Chloe was thirteen. How times have changed, and today we are biologically adult many years before society is prepared to accept us as socially adult. Perhaps it is that with the expectation of life lengthening, there is no hurry for a youth to get married and to take his place in the world.

It is also interesting to recall that married women born in England and Wales between 1840 and 1860 had on an average between five and six children: those born between 1925 and 1929 by contrast had on an average 2.2 children. The Victorian group had 20% of families with two children or fewer, and 33% of families with eight or more. In the 1925-29 group, 67% of families had two children or fewer, and only 2.3% had eight or more. It is apparent that the one-child and two-child family has been substituted for the family of five, six, or seven, as the commonest family size. It must also be recalled, though, that a baby's chance of surviving the first year of life is some four to five times greater in recent times than in the Victorian era.

Small families in themselves may raise social, medical, and administrative problems in the future. There is no better or more understanding company for a child than another child, and one-child, or even two-child families, are not without their own particular social problems. Small families will encourage the association of young children outside the home and not in the home.

Where the first pregnancy these days is generally viewed as a "trial run" and a matter for the hospital or nursing home, this might even have a future reflection on the size of the midwifery services, as well as affording the general practitioners with fewer confinements. As the members of small families reach middle and old age, there will be a diminished circle of relatives to care for them and to temper the loneliness of old age, with consequent increasing responsibilities falling upon the State. The total school population will decrease, and this, generally speaking, is beginning to show in the infants' section at the moment. Indeed, our future housing policy cannot be disassociated from the family size.

These are, of course, only speculations, and the actual tide of events may well prove them wrong, as is often the case.

The Birth Rate for England and Wales was 15.2 per 1,000 population. There was one illegitimate birth during the year.

DEATHS

	Males	Females	Total
Deaths from all causes	68	73	141

DEATH RATE

11.8 per 1,000 estimated population

1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943
14.1	10.9	13.9	13.7	14.1	11.6	12.7	12.5	13.0	10.8	14.2

1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954
11.7	11.0	12.4	10.0	11.5	11.8	11.0	11.1	13.8	11.7	11.8

The Death Rate shows a very slight increase on last year, but there has been little change over the last twenty years. The rate for England and Wales is 11.3 per 1,000 population.

The commonest causes of death were (see page 27), (1) heart diseases and diseases of the circulatory system, (2) vascular lesions of the circulatory system, and (3) cancer, in that order.

The number of people who die from heart disease each year seems to have increased gradually over the years. This does not necessarily mean that heart disease is on the increase. In fact, there is good evidence that heart disease is not actually on the increase, but decreasing in importance as a premature cause of death. The reason for this apparent increase in heart disease is probably this.

There is a great reduction in deaths from tuberculosis, pneumonia, and the acute communicable diseases of childhood, which used to cause a considerable number before middle-age. This has meant that many people have survived to die later of heart disease, as the risk of death is greater at the far end of the life span. In other words, the longer a man lives, the greater is the likelihood of finally dying from heart disease, or what might be more accurately termed heart failure, as it is inevitable that the heart must wear out and stop beating sometime.

From the following table of the number of deaths during the various months of the year, it can be seen that a greater number occur from October to March than during the other six months. Nevertheless, an appreciable number do occur during our Summer season. Perhaps this is not surprising, as there seems to have been little difference between 'Summer' and 'Winter' during the last few years, except in name.

DEATHS PER MONTH OVER THREE YEARS

	1954	1953	1952
January	16	13	13
February	16	19	24
March	14	18	16
April	13	19	12
May	13	9	12
June	6	10	5
July	5	3	12
August	9	9	7
September	4	5	13
October	14	10	16
November	10	13	14
December	21	12	19

This does not only apply to deaths, but is also the accepted view with regard to "rheumatism" with its major and minor aches and pains, colds, etc., and conjures up a vision of that depressing side of Winter which is so familiar to us all, and so different from the traditional Winter scene beloved by the designers of our Christmas cards. It might even be said that they are the price the inhabitants of these Islands have to pay for living in 'this sceptred isle'.

Let us consider the problem and try to discover, if possible, the connection. When discussing 'Winter', it is cold which first and foremost comes to mind as the most important contributing factor. Nevertheless, this does not appear to be the whole story, as, for example, the rheumatic diseases are said to be rare among people of the far North, such as the Eskimos, just as the incidence is equally low in the tropics.

Humidity is another factor. Here again, every country in the world seems to have its own pet spot to achieve a "cure" for the various aches and pains. Some nations prefer the moist coastal areas, others choose a mountainous area, while a group of opulent wanderers travel widely into foreign countries, all seeking relief. Climatic conditions, however, do have an effect upon the human body, but in just what way is too little known. In other words, dampness has been generally accepted as having an evil influence upon the human body, as is well realised by those suffering from certain forms of rheumatism.

There is, however, another important factor. The intensity of pains and aches at any time may well be dependent on what is generally termed "morale". This has been defined as 'the sum total of all those factors determining physical, mental, and emotional

well-being'. One's morale is very important and reflects our outlook to a remarkable extent. Morale is itself much influenced by physical factors such as the brightness of the day, the warmth of the atmosphere, and the ease with which locomotion can be carried on. The sight of growing and flowering vegetable life is uplifting to morale, whilst the news of an ill relative, or friend, is correspondingly lowering. Thus it is that during the dark, cold, and often wet weeks of January and February, when one's friends or associates are ill, or in the hands of the undertaker, when the trees are bare, and no birds sing, some degree of depression with introspection may be induced, so that minor pains and aches take on an ominous significance, and, as their intensity increases, the victim is found hurrying to his doctor in search of a diagnosis and cure. Then it is that the Summer molehill of discomfort can so easily become the Winter mountain of unbearable pain or even death.

"Old Winter, sad, in snowy clad
Is making a doleful din:
But let him howl till he crack his jowl
We will not let him in.

Let his baleful breath shed blight and death
On herb and flower and tree:
And brooks and ponds in crystal bonds
Bind fast, but what care we?"

"Old Winter" - T. Noel.

Perhaps Robert Burns, in his native wisdom, but I hope not native vigour, had his own answer for the prevention of Winter discomforts when he wrote:-

"Up in the morning's no for me,
Up in the morning early;
When a' the hills are cover'd wi' snaw
I'm sure it's Winter fairly."

The number of deaths from cancer is the same as last year, and represents 11% of all deaths. The average age of the cancer deaths in males was 66 years, and in females 63 years. Cancer of the lung and bronchus accounted for four deaths in males and one in females.

Cancer Mortality Rate (all forms) taken in triennial periods

1925 - 27	.....	1.6	1940 - 42	.....	1.7
1928 - 30	.....	1.8	1943 - 45	.....	1.4
1931 - 33	.....	1.9	1946 - 48	.....	1.3
1934 - 36	.....	1.7	1949 - 51	.....	1.9
1937 - 39	.....	1.8	1952 - 54	.....	1.4

Over the last few years, the Cancer Mortality Rate seems to be levelling out at a rate around 1.4 to 1.5. During the pre-war period, the rate was higher, probably because of a high percentage of elderly people in the District. With the introduction of more industry, the population becomes more evenly balanced with young and

old. There is still a higher average of old people than for England and Wales as a whole, because the Registrar General gives a death comparability factor for the District of 0.87.

There were no maternal deaths attributed to pregnancy, child-birth, or abortion.

Infant Deaths (under 1 year of age)

	Males	Females	Total
Legitimate	2	3	5
Illegitimate	-	-	-
Totals	2	3	5

Infant Mortality Rate

26.0 per 1,000 live births

1925 -27	1928 -30	1931 -33	1934 -36	1937 -39	1940 -42	1943 -45	1946 -48	1949 -51	1952 -54
60	62	54	40	47	49	32	29	29	24

Infant Deaths (under 4 weeks of age)

	Males	Females	Total
Legitimate	2	2	4
Illegitimate	-	-	-
Totals	2	2	4

Neonatal Death Rate

20.7 per 1,000 live births

Still Births

	Males	Females	Total
Legitimate	1	2	3
Illegitimate	-	-	-
Totals	1	2	3

Still Birth Rate

15.4 per 1,000 (live & still) births

Five deaths occurred in babies under one year, and, of these, four died during the first four weeks of life. Three babies were stillborn, or, in other words, did not show any sign of life at birth. It is probable that the same "toxic" factor which caused the babies to be stillborn also played a large part in the deaths under four weeks. Indeed, it might well be argued that the same factor, or factors, acting in a stronger or more toxic form produces abortions or miscarriages earlier in pregnancy. It may also be possible that some of our congenital deformities may be due

to that same factor acting in a lesser degree on a particular organ. This may be over-simplifying the problem, but, up to the moment, we know very little about it. One thing is certain, however, and that is that the above rates will alter little until our understanding of the problems associated with child-birth become clearer.

Causes of Infant Mortality

Under Four Weeks

Prematurity	1
Pulmonary Atelectasis	1
Asphyxia - Liquor Amnei	1
Asphyxia - Overlying	1

Four Weeks to Twelve Months

Peripheral Circulatory Failure
(Resection of Gut - Intussusception) 1

Again, attention is drawn to the need for expectant mothers to avail themselves fully of the vitamin supplements supplied practically for the asking. Our frequent grey skies and lack of sunshine make these a necessity. Indeed, a recent survey has shown that a large percentage of expectant mothers are anaemic and require iron as well. It has been stated in the Editorial of a recent British Medical Journal on "Iron Deficiency in Pregnancy":- "Unless haemoglobin estimations can be done as a routine, oral iron should be prescribed for all pregnant women..... The attainment and maintenance of a high haemoglobin level during and after pregnancy not only increases the margin of safety for mother and foetus, but it also ensures the woman a quicker recovery from child-birth, and gives her more energy to resume her household duties, and to enjoy her motherhood".

The Infant Mortality Rate for England and Wales was 25.5 per 1,000 live births, and our own average over the last three years is slightly lower than this.

GENERAL STATISTICS - 1954

Area of District	46,733 acres
Population (Estimated Mid-Year)	11,970
Number of Occupied Houses	3,900
Rateable Value (31st March, 1954)	£55,887
Product of Penny Rate	£218

Population

It will be seen that the Registrar General's estimate for our mid-year population is 11,970. This is thirty higher than last year. The number of occupied houses is 3,900, and this shows that in the District there are, on an average, 3.07 persons per household. In England and Wales in 1951, there were 3.19 persons per household.

Age Incidence of Death

	Males	Females	Totals	Percentage
Under 4 weeks	2	2	4	2.8
4 weeks - 1 year	-	1	1	0.7
1 year - 4 years	-	-	-	-
5 years - 14 "	-	-	-	-
15 " - 24 "	2	-	2	1.4
25 " - 34 "	3	-	3	2.1
35 " - 44 "	-	-	-	-
45 " - 54 "	3	7	10	7.1
55 " - 64 "	12	7	19	13.5
65 " - 74 "	14	15	29	20.6
75 " - 84 "	27	29	56	39.7
85 " - 94 "	5	11	16	11.3
95 " - 100 "	-	1	1	0.7
100+	-	-	-	-

A very encouraging picture - 72% of those who died exceeded the age of 65 years, and 52% exceeded 75 years of age. In other words, over 72% of us should live to draw the Old Age Pension, and 52% will be able to draw the pension for at least ten years, with more to come. Let us hope that when we stagger along, "cap in hand", the contribution will make the journey worth while. The prospect of a long life seems assured in Lutterworth Rural District, although it is also said that, "Only the good die young"!

Let us look again at the table and observe that one woman exceeded ninety years, whereas all the men had fallen by the way-side; indeed, her age was 99 years.

The average age at which the males died in Lutterworth Rural District was 69 years, whereas the women were given a little more grace and reached 74 years. In England and Wales, the expectation of life at birth in 1953 was 67 years for males and 72 years for females, whilst in 1871-80, it was 41 years for males, and 45 for females.

Although pleased with ourselves, let us not be too parochial in our outlook and cast a thought to the plight of young and old elsewhere in the world, which through modern methods of travel, seems to be getting smaller and smaller. The World Health Organisation reminds us that two-thirds of all the people in the world are under-nourished and have an expectation of life of no more than thirty years - just about what we in this country enjoyed during the reign of Elizabeth I. The candle of life burns long for us now, and has become guarded more and more against the ill-winds that used to blow it out so tragically soon.

Increase of Births over Deaths

1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943
-4	40	-12	-10	6	35	23	23	12	64	57

1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954
102	75	83	140	114	72	81	70	29	58	50

During the year there was a natural increase of the population of 50.

One might get the impression that at the present time old people are living longer. This is a misconception. What is happening is that many more of us are now attaining the age of sixty-five than was the case formerly, and it is only in this sense that we are becoming an older population. We are still a long way from becoming a nation of centenarians. "Perhaps some of us may not want to achieve treble figures!" This is often a casual statement made by the 'younger' generation, but it is a good bet that when their time comes, they will hold on to the threads of life as tenaciously as the present old ones. At any rate, we really have little choice in the matter, but I am certain we shall not be as heroic as the people at Grantchester, recorded by Rupert Brook:-

"And when they get to feeling old
They up and shoot themselves I'm told."

That would solve the problem of housing for old people, would it not!

With the birth rate falling, the death rate remaining fairly constant, and more people on the average living longer, the long term change in the population is expected to be that there will be on the one hand more old people, and on the other, fewer children. This brings us once again to consider further the problems of the aged. There is no doubt that any scheme that enables the old folk to maintain contact with normal life, and, particularly family life, deserves support and encouragement, and is certainly kinder and more economical than admission to a home or hospital. I am, however, extremely pleased to record that the members of the Council are very conscious of the problems of the old people, and that interest is not only confined to those ageing themselves, but also the younger ones.

During the year, active discussion has taken place on this subject, and this will no doubt show itself in a more tangible form in the near future. A full report on the problem of the aged and recommendations with regard to all aspects of housing was presented to the Housing Committee by your Medical Officer of Health, and accepted by them. It will not come amiss, however, to discuss some other aspects of old age.

The building of old people's houses seems to have been accepted as one of our acknowledged duties to the community. As, has been pointed out earlier in the report, with the falling birth rate, there is a tendency for more one-child or two-child families. Consequently, there will be a diminishing circle of relatives to care for and look after the aged, with new responsibilities falling on the local authorities. At the present moment, there is often great difficulty in persuading a son or daughter out of a family of four or five to look after one of their own parents, so that the parents can live out their earthly existence in their own home, and in the surroundings that they know and have enjoyed for years. It is therefore very important that suitable homes should be provided for the aged so that their burdens are the minimum, and they can live an independent existence as long as possible in their own surroundings.

It might also be pointed out that when an old person requires care and attention and is admitted to a Residential Home, like Woodmarket House, it is quite a costly business to keep him there. For example, the estimated cost for this year to the County Council of keeping old people in Residential Homes is £5.8s.6d per person per week, and in one of the new Homes recently opened, is £6.13s.0d. per person per week. Also the cost of building Homes at the moment is no small amount, and there are several under construction, with a few more being planned.

There is a great deal talked at the present time of welfare facilities provided by the County Council for groups of old people's bungalows. The practical point of the number of bungalows built on a site where welfare facilities would be required, or even asked for, has yet to be settled. An absolute minimum, and I very much doubt if it would be practicable, would be twelve. Then, out of this twelve, one would have to be occupied by a Warden, who, with his wife, would generally supervise and help. The Warden's facilities would be provided by the County Council, central heating

would also be supplied by the County Council, and probably a Club Room for social amenities. This is the general idea, but can we afford one bungalow in every twelve for a Warden, or, for that matter, Club Room space where two more bungalows could have been built?.

Also what about the generally held and accepted view that old people should not be dumped together and segregated from the rest of the community! Remember what a Minister of Health said. "I hope that old people will not be asked to live in colonies of their own; after all, they do not want to look out of the windows on endless processions of funerals; they also want to look on processions of perambulators.....therefore, I hope that local authorities will arrange their schemes in that fashion". A further point is that the average old person is not infirm nor incapable of looking after the great majority of his needs. There is a tendency among certain people that the more there is done for them, the more they expect to be done, and so a circle of inactivity sets in leading to helplessness and complete dependence. This has to be watched. At any rate, with a careful selection of tenants, surely there could be found one not-so-elderly who would undertake to do odd jobs for the others, provided, of course, that the old people themselves wish assistance!.

Let us consider it from another point of view. Where in this District will units of twelve old people's bungalows be required, even if, regardless of other commitments, (slum clearance, individually unfit houses, the ordinary housing lists, and the reduced building allocation), it was thought necessary to build them?. At the moment, it is felt that the Council will be doing its duty if old people's accommodation is built in units of twos, fours, or sixes, in convenient accessible places not far removed from their original abode. Time may alter this opinion, and this subject should be kept constantly under review, as there is little doubt the problem will increase.

The next question is what type of bungalow accommodation should take priority - one bedroomed, or two bedroomed?. Moving around the District, it is found that the great majority of old people have their relatives, either in the village, or very near at hand. We are not, generally speaking, catering for the type of person who has left his home surrounds and gone to live in another part of the country, and when he takes ill the relatives who come to see him cannot return home that same day.

At the present time, the majority occupy one bedroomed cottages, or small houses. This is what they have been used to and is just about within their limits to furnish and keep clean. The furnishing is an important point, as old people will undoubtedly take all their treasured bits and pieces with them. If they have not the furniture to furnish the extra bedroom in a two-bedroomed bungalow, and few of them have, then it is useless providing one, as well as more expensive to do so. After all, how often do we use our 'spare' room?. As a rough estimate from visiting many old people in their homes, it is reckoned that there should be at least four single bedroomed bungalows to every one double bedroom.

Another interesting problem is the age best suited for old people to move into a new house. After being in the same house for a number of years and knowing instinctively every step, every corner, and every electric switch, where to find the brush, the knitting basket, the pipe, the matches, the crockery, the knives and forks, the poker, etc., it takes quite considerable readjustment and control of temper to accustom oneself to a new environment, even for a young person. As you cannot expect an old dog to learn new tricks, nor can you expect an elderly person of seventy-five with failing vision, unsteady step, and a limited capacity for work, to master the whereabouts of a new house. This change over has to be accomplished as early as possible.

I well remember an old man living by himself, who never removed the frying pan from the top of the gas stove, accusing a Home Help, after her first visit, of stealing, when in her own way of 'tidying-up', she put the frying pan in the adjoining cupboard. The old man had learnt to expect the frying pan to be in that one position, as, indeed, many other things in the house had their own fixed position. How would he have fared if removed to a modern bungalow?

Consideration of the housing needs of the aged has to be on a long-term basis, and, although there is a definite need at the moment, and this will increase, it is worth while to tread warily, and, where possible, bungalows should be built in small groups and offered to those in the early retiring age, as they are best able to cope with the problems of a new house at that time.

The extent of the problem will become clearer as time goes on, and when it is generally known that bungalows are available for those of retiring age, then the future building programme can be judged from the waiting list and the type of accommodation most requested. After all, we may know, for example, it would be a good thing for old people to vacate large houses which are much too big for them, but we must respect the right of the aged to keep their own homes, even if they are too large. This is where gentle persuasion is required, and this can be more effective at sixty-five than seventy-five!

On visiting old people around the District, it is amazing how many of them rely on a little private store of some sort of alcohol, usually whisky, as a nightcap, or taken on occasions with a meal. It is very often suspiciously tucked away in the remotest part of the house, and disguised in all sorts of bottles with the most repellent and poisonous types of labels. There is a certain feeling of guilt about it all and suspicion lest the neighbours should find out their private habits.

It is good to feel, however, that in their solitude and loneliness, they at least go to bed with a song in their hearts and a sense of well-being and freedom from worries. Perhaps as they sit in their chairs before the dying embers of their meagre fires, or mount the stairs for bed, they are quietly reminiscing and humming a song that takes them back many, many years - the tune may not be recognisable, but the words are quite sincere.

Another problem is one that is looked at from the County as a whole. It is considered that it is only in the larger urban areas of the County that old people's bungalows will be built in sufficient numbers to warrant welfare facilities provided for by the County Council. In the rural areas, and possibly where there is a higher percentage of old people, the need for old people's accommodation will be met by small groups of bungalows in the villages, without welfare facilities.

It is more expensive to provide small groups of bungalows than it is to build large numbers, and this expense is falling on those rural areas which can least afford to build an expensive type of house. Conversely, the richer urban areas can build their bungalows cheaper, and, as well as this, the County Council will, in all probability, provide welfare facilities.

By building accommodation for old people, it is probably one way of reducing the waiting list for Residential Homes. This is very much in the interest of the County Council considering the expense of running these Homes and the cost of building new ones. Consequently, it is considered that the County Council should be asked to off-balance this discrepancy, so that if there is any financial aid for the provision of accommodation for old people, at least it should be used so that the cost to the Rural Districts to build this specialised type of accommodation should not be greater than for the Urban Districts. The urban areas will, of course, also benefit by the County Council providing their welfare facilities, so that, in the long run, they receive a much larger slice of the financial pie.

Health Generally

In last year's report, the very low standard of sanitary cleanliness that existed at most of the schools in the District was mentioned.

I am now very pleased to record that since then there has been a very great improvement. This improvement has certainly been appreciated by the teachers, and I am sure, also the children, most of whom come from good homes where the standard of cleanliness is high.

In fact, many of the schools have also installed small hand-wash basins. The only thing they now lack is running hot water. Several schools in the District already have this, supplied from a tank with an electric immersion heater. There is no good reason why the remainder should not also be provided with it. A full report has been sent to the County Council, particularly on this matter. Meals are served at a great number of our schools, so running hot water is of importance. As well as this, children should be set a good example at school, and the elements of personal hygiene taught as well as shown, so that these become so inculcated that they are an automatic habit for the rest of their lives.

It is a generally accepted view that the time has been reached when the individual must play a greater part in the campaign for better health, if the incidence of disease is to be still further diminished. It has been suggested that this would be achieved if more attention were paid to the simple rules of health relating to diet, exercise, relaxation and rest, food hygiene in the home, shop, and canteen, dental care, and cleanliness generally.

The individual can do this, particularly in the food hygiene sphere, by demanding and being critical of the standard of hygiene in the shops, canteens, restaurants, and cafes. This should encourage the progressive food trader and stir-up those who are not so progressive.

The law lays down only a basic, or minimum standard, and a higher standard will only come from persuasion on the part of officials, or, better still, free criticism on the part of the customer demanding a higher hygienic standard.

PREVALENCE AND CONTROL OF INFECTIOUS DISEASES

Total Number of cases of Infectious Diseases
notified during the Year 1954

NOTIFIABLE DISEASE	Number of Cases Notified at Ages								TOTAL DEATHS
	Under 1 year	1-5 yrs.	5-15 yrs.	15-25 yrs.	25-45 yrs.	45-65 yrs.	65 & up- wards	At all ages	
Scarlet Fever	-	1	2	-	-	-	-	3	-
Whooping Cough	5	21	27	-	-	1	-	54	-
Diphtheria	-	-	-	-	-	-	-	0	-
Measles	1	9	8	-	1	-	-	19	-
Pneumonia	-	1	1	2	4	1	-	9	5
Meningococcal Infection	-	-	-	-	-	-	-	0	-
Poliomyelitis	-	-	-	-	-	-	-	0	-
Dysentery	-	2	7	-	1	-	-	10	-
Ophthalmia Neonatorum	-	-	-	-	-	-	-	0	-
Puerperal Pyrexia	-	-	-	-	-	-	-	0	-
Enteric Fever	-	-	-	-	-	-	-	0	-
Food Poisoning	-	-	-	-	-	-	-	0	-
Erysipelas	-	-	-	-	-	1	-	1	-
Pulmonary Tuberculosis	-	-	-	4	1	1	-	6	1
Other forms of Tuberculosis	-	1	-	-	-	-	-	1	-

Infectious Diseases (other than Tuberculosis)

Average per Year in Triennial Periods

	1925 - 1927	1928 - 1930	1931 - 1933	1934 - 1936	1937 - 1939	1940 - 1942	1943 - 1945	1946 - 1948	1949 - 1951	1952 - 1954
Smallpox	-	5	1	-	-	-	-	-	-	-
Scarlet Fever	6	41	20	32	9	10	11	9	5	2
Whooping Cough	-	-	-	-	-	3	13	8	22	32
Diphtheria	6	9	2	5	2	8	0.3	-	-	-
Measles	-	-	-	-	-	3	38	65	115	56
Pneumonia	14	13	15	7	13	3	9	9	4	14
Meningococcal Infection	-	-	-	-	-	1	-	-	-	0.3
Poliomyelitis	1	0.7	0.7	0.7	0.3	0	-	0.7	1	0.3
Dysentery	-	-	-	-	-	-	-	-	-	2
Ophthalmia Neonatorum	1	0.3	1	1	1	-	-	-	-	-
Puerperal Pyrexia	0.7	0.7	1	0.7	3	-	1	0.3	0.3	1
Enteric Fever	0.3	2	-	0.3	-	0.3	-	-	-	-
Food Poisoning	-	-	-	-	-	-	-	-	-	0.3
Erysipelas	2	2	1	2	3	0.3	0.7	0.7	0.3	2

General Comment

The total incidence of infectious diseases in 1954 is lower than in the previous year. Whooping cough was responsible for the greatest number, with measles and dysentery next.

Most of the cases of infectious diseases occurred as would be expected, in the school-age group of 5-15 years. This is the age when there is general intermixing and intimate contact at a time when the infectious diseases are not recognised as such, and when they are most infectious. The infection is then carried home and spread amongst the pre-school group, 1-5 years. A noteworthy exception to this is pulmonary tuberculosis, where the first cases occurred after the school period, 15-25 years.

It will also be noted that during the year there were no cases of diphtheria, typhoid fever, meningitis, poliomyelitis, or ophthalmia neonatorum.

There is a great deal to be thankful for in this happy state of affairs, when one recalls the ravages of these infections in bygone days. For example, take ophthalmia neonatorum only a few years back. It has been stated that:- "In the nineteenth and early part of the twentieth century, thousand of eyes were destroyed by purulent conjunctivitis of the new-born." Indeed, chiefly because of the control of eye infection in recent times, it has been estimated that nearly half of the 100,000 blind community of Great Britain are more than seventy years old.

Thinking of infectious diseases, it has been suggested that public telephones may be a means of transferring infection among the users. With this in mind, a survey was made in the London area and reported on by R.E.O. Williams, M.D., B.Sc. In this, the mouthpieces and earpieces of a total of 153 telephones in offices and public kiosks were examined bacteriologically.

The instruments in public kiosks in Central London are, as a routine, cleaned by wiping with a cloth moistened in a proprietary phenolic disinfectant three times a week. From this survey, it is clear that public telephones are not often heavily contaminated with known pathogenic bacteria, (i.e. germs causing disease in man). Moreover, the removal of contamination from the mouthpiece by blowing is not very easy, because germs are sprayed on to the mouthpiece in saliva, or sputum, and they become firmly fixed when this dries.

Provided the user does not touch the mouthpiece during use - and there is no need to do so - the danger of acquiring infection from any contamination that may be present appears to be small. The earpiece is more likely to spread infection because of actual contact, but then, generally speaking, infectious diseases are not spread via the ear.

In conclusion, Doctor Williams says:- "It seems improbable that there is any appreciable risk of respiratory infection being transmitted by way of telephones in ordinary use." It is satisfactory to be assured that the use of so valuable a means of communication is without any attendant danger, and that the only precaution advisable is the obvious common-sense one of keeping the mouthpieces and earpieces clean.

I have been assured by the telephone authorities that the telephones in this District are cleaned with a proprietary disinfectant once a week.

Scarlet Fever

The number of cases of scarlet fever reported during the year is the same as for the previous year. All the cases were nursed at home.

It is rarely necessary in the patient's interest to require hospital treatment these days, for this condition which is now mild in type. However, isolation away from home may in certain circumstances prove necessary in the community's interest, e.g. in

the homes of milk or food handlers.

Whooping Cough

There was a slight increase in the number of cases of whooping cough reported during the year - 54 in comparison with 29 in 1953.

The majority of cases occurred between the ages 5 and 15 years, with an appreciable number between one and five years, but there were five cases under one year.

It is rather a sad and pathetic sight to witness a baby having spasms of coughing, and not yet having acquired the art of bringing up phlegm, or clearing the throat. However, our new methods of antibiotic treatment greatly lessen the severity of the attacks if given sufficiently early. As whooping cough today is a mild infection in the healthy, older infant, it has been suggested that antibiotic treatment should not be given here, so that the infant may be allowed to build-up its own natural resistance, otherwise, there is the possibility of yet another attack later on.

"Up in the North, a long way off,
The donkey's got the whooping cough."

Diphtheria

There were no cases of diphtheria notified during 1954 - a tribute in itself to our immunisation programme. The last case was in 1943 when there was one victim; but let there be no doubt about the position, that the complete defeat of diphtheria is only dependent on a high state of immunisation. If this is not maintained, then there is a danger of diphtheria returning. What a panic there would be, and how dreadfully sorry some parents would find themselves! - all because of two simple injections which cause little or no discomfort.

It is also emphasised that there has been little advance in the treatment of this disease when compared with other diseases, and that the relative scarcity at the present time may result in delay in diagnosis and treatment, if, and when, the disease is re-introduced, with its obvious tragic consequences.

Arrangements for immunisation are the responsibility of the Leicestershire County Council. The procedure adopted by them is that when a child attains the age of eight months, a letter is sent to the parents regarding immunisation against diphtheria. The parents are asked to make the necessary arrangements with their own family doctor for the treatment - a combined "request and consent" card being supplied for this purpose. Attached also is a pre-paid card notifying the intentions of the parents to the County Health Department.

If no consent is received from the parents, or no completed certificate is received from a general practitioner, a health visitor investigates the case and endeavours to persuade the parents to allow the child to receive the appropriate treatment.

The general practitioners, who receive supplies of material free of charge, have co-operated well, some of them holding special sessions at their surgeries, particulars of which are known to the health visitors, so that children can be dealt with without delay. No immunisation is undertaken by the Council's medical staff, except for a few cases where for some reason or other the services of a general practitioner are not readily available.

A further letter urging a booster dose of diphtheria prophylactic is sent to the parents some little time before the child is due to enter school.

The following table shows the number of children immunised in this District during the past eight years.

Number of Children Immunised					
YEAR	Primary			Re-immunised	Number of babies born during preceding year minus deaths under 1 year
	Under 5	5 - 14	Total		
1947	196	26	222	189	213
1948	186	45	231	415	240
1949	191	7	198	58	239
1950	143	12	155	60	206
1951	137	12	149	90	202
1952	144	5	149	66	195
1953	139	4	143	126	186
1954	154	3	157	106	195

To obtain some idea of the proportion of children immunised, a rough and ready way is to compare the number of primary immunisations under 5 years of age, with the number of births during the preceding year, who survived that year. This has been done in the table and gives a percentage of 79.

Looking at it in another way, from 1946-53, there were 1,676 babies born, and from 1947-54, there have been 1,404 primary immunisations - giving a percentage of 84. Re-immunisations, which are just as important to maintain a high level of immunity, seem to be lagging behind.

Measles

The year was a very lean one for measles, 19 cases being recorded. This fits in very well with the characteristic picture of this disease which seems to come in waves every other year, as we well know at the time of writing.

Poliomyelitis

It is pleasing to record the complete absence of this disease in this District during 1954.

The Chief Medical Officer of the Ministry of Health in his report for 1953 stated:- "Whilst the prospect of an effective and practicable means of vaccination against poliomyelitis seems better now than hitherto, there may be considerable wisdom in making haste slowly; for much remains to be determined..... Much patient work will yet be needed before poliomyelitis is controlled, and we must beware of proclaiming victory before the battle is even properly joined". The wisdom of these words is borne out by the events which recently happened in America.

Dysentery - Sonne

During the year, there were 10 notified cases of Sonne Dysentery, all being confirmed by bacteriological examination. It should be recalled that during the year there were many cases in a nearby large urban area, and scattered cases in the adjoining rural district.

The first case occurred during January at Peatling Magna and was a single isolated one in a family of four.

All the other 9 cases were at Broughton Astley and involved five families. The initial case in each family was in a school child, which included four girls and one boy, their ages being 5, 5, 6, 8, and 10 years. All attended the village school and the first symptoms occurred between the 7th and 15th of May.

The average period of isolation for child cases and child contacts was 42 days - the shortest being 31 days, and the longest 60 days. For school children, this represents an appreciable loss of educational time. The reason for this is that many children required two and sometimes three courses of treatment before the requisite negative samples could be obtained. There is little sense in allowing child contacts back to school while there is a positive case in the household. Perhaps more use of the newer antibiotics will in future lessen this period of isolation and quarantine.

Attack Rates

In those exposed to a case in the family

Age	Number Exposed	Cases	Attack Rate (Per Cent)
0 - 4	4	2	-
5 - 10	9	6	-
11 - 14	5	1	-
15 +	16	1	6
All ages	34	10	29

From this, it will be seen that in all 34 people were exposed to infection, and 10 became infected, giving an attack rate of 29%. Six out of nine children between the ages 5-10 years became infected.

One strong impression gained from following these dysentery cases is that where there are a number of children in the house, it would be rare if more than one did not become infected.

On receiving notification of a case of dysentery, the house is immediately visited. A general talk is given to the mother on the condition in general, and particular attention directed to the means of spread. All school contacts are excluded from school and the parents are advised on house and garden isolation, but they could go for a walk provided they were supervised and kept to themselves.

The schools where the children attend are also visited and the head-teachers requested that on the slightest suspicion of any children having bowel symptoms, they are to be sent home and the mother instructed to call in the doctor. Also, a talk is given to the children on the great importance of hand-washing after being to the lavatory and before each meal.

In each case, three negative faecal samples were obtained before being allowed back to school, and all school contacts had the same. Generally speaking, mothers were very co-operative, but there were occasions when faecal specimens were not readily forthcoming from fathers.

All told, it is felt that our strict methods did bring a measure of reward, as there could have been a more widespread infection. It may have been that with the infection being a mild one in the majority of cases, a correct diagnosis may not have been made, or patients did not trouble to seek medical advice. I do not think this was likely in school children, as the teachers kept a very vigilant look-out, and information would have been received about any child having bowel symptoms.

It will also be appreciated that after the initial cases at Broughton Astley, there were no further notifications, even though the infection seemed to start at school.

Sonne dysentery is an infection of the large intestine resulting in diarrhoea, which, if sufficiently severe, may be accompanied by bleeding. The vast majority of cases today are very mild, presenting little more than a transient diarrhoea, without any blood, especially if the victim is a previously healthy adult or adolescent. Yet the same infection in a small child or debilitated adult may be serious, if not fatal.

It is generally looked on as a "contagion", spread directly from case to case with symptomless excretors and convalescent carriers playing some part. Food-borne outbreaks do occur from time to time, but they are uncommon. It is an infection which can spread where the standard of hygiene is relatively high. This rather suggests that the infecting dose of the germ is small.

It has been stated that in the large centres of population, dysentery is probably always present. At some times, it is confined to relatively small areas, not necessarily characterised by poor housing and overcrowding; at other times it spreads widely from these centres through the suburbs and into the surrounding country-side, but may miss completely many small and some large centres of population. The factors that determine whether the infection will spread widely, or not, are not well understood - immunity of the population, housing conditions, social behaviour, even the weather, may all play a part.

It would be a council of despair to recommend taking no action to prevent its spread, although there is quite a lot about the means of spread that we do not understand. On the other hand, to exclude all infected persons from school, or work, or from the society of their friends and neighbours, would entail more dislocation than the severity of the infection warrants. A middle course is usually steered, and much reliance is placed on the good hygienic sense of adolescents and adults.

Tuberculosis

Six cases of pulmonary tuberculosis, and one case of non-pulmonary tuberculosis were notified during the year. There was one death.

Number of New Cases and Total on Register

	Pulmonary		Other Forms of Tuberculosis	
	Male	Female	Male	Female
New Cases	3	3	1	0
Total on Register at 31st December 1954	27	16	10	5
TOTAL	43		15	

Pulmonary Tuberculosis - New Cases

Age of Males	18, 21, 41	years
Age of Females	16, 20, 64	years

It is rather tragic to think that so many young people develop active pulmonary tuberculosis. The age period 15-25 years is one where it is well known that the incidence of tuberculosis has increased, and, it is for this reason, that a tuberculin skin test with B.C.G. vaccination, where necessary, is now being offered to all school leavers in the County. As well as this, mass radiography, or a miniature Xray, is available for all those over thirteen years of age, free of charge, merely by making an appointment. The procedure is a lot shorter than what men go through to have their hair cut, and is certainly a great deal simpler than what our tolerant wives and sweet-hearts endure in having their beauty treatment. Which is the more important? Still hair comes before health in many cases! Think of it - attend once a year, and in and out in less than ten minutes. What could be easier?

In a memorandum on 'Prevention of Tuberculosis' issued by the Ministry of Health is the following:- "Prevention of spread of the human type of bacillus is well known to be a matter of avoidance of respiratory infection and such infection arises from contact, more or less intimate, with other active respiratory cases. It may occasionally arise from the inhalation of dust contaminated with dried sputum without any contact with an infected person, but it is common knowledge that the likelihood of primary infection depends mainly upon the intimacy of contact with an infected person".

The control of tuberculosis hinges mainly on finding every person with an active infection. Here we are dependent a great deal on individuals coming forward and making full use of the facilities which are offered for early diagnosis. It may be a little hard at the time to face realities, but, in the long run, it might save a great deal of human suffering and misery.

DEATH FROM ALL CAUSES

	1954		
	Males	Females	Total
1. Tuberculosis, respiratory	1	0	1
2. Tuberculosis, other	-	-	0
3. Syphilitic disease	-	1	1
4. Diphtheria	-	-	0
5. Whooping Cough	-	-	0
6. Meningococcal infections	-	-	0
7. Acute poliomyelitis	-	-	0
8. Measles	-	-	0
9. Other infective & parasitic diseases	-	-	0
10. Malignant neoplasm, stomach	-	2	2
11. " " lung, bronchus	4	1	5
12. " " breast	-	2	2
13. " " uterus	-	-	0
14. Other malignant & lymphatic neoplasms	4	3	7
15. Leukaemia, aleukaemia	-	-	0
16. Diabetes	-	-	0
17. Vascular lesions of nervous system	7	11	18
18. Coronary disease, angina	7	1	8
19. Hypertension with heart disease	1	6	7
20. Other heart disease	22	29	51
21. Other circulatory disease	2	1	3
22. Influenza	-	-	0
23. Pneumonia	3	2	5
24. Bronchitis	4	1	5
25. Other diseases of respiratory system	-	1	1
26. Ulcer of stomach and duodenum	1	-	1
27. Gastritis, enteritis & diarrhoea	-	-	0
28. Nephritis & nephrosis	-	-	0
29. Hyperplasia of prostate	1	-	1
30. Pregnancy, child-birth, abortion	-	-	0
31. Congenital malformations	-	-	0
32. Other defined and ill-defined diseases	7	10	17
33. Motor vehicle accidents	1	-	1
34. All other accidents	2	1	3
35. Suicide	1	1	2
36. Homicide and operations of war	-	-	0
ALL CAUSES	68	73	141

REPORT OF THE
SENIOR SANITARY INSPECTOR

Mr. Chairman, Lady and Gentlemen,

I beg to submit a brief report on the work of the Health Department during the year 1954.

HOUSING

New Dwellings

During the year only 14 permanent houses were completed by the Council, and during the same period, 23 houses were built by private enterprise. At the 31st December, however, there were 92 permanent houses in course of erection by the Council, and 15 by private enterprise, and the number which will be completed during 1955 will maintain the Council's average of approximately 50 houses per annum.

Converted Army Camps

The Council have continued their policy of dismantling converted army camps, and have decided to rehouse the tenants from a hutted camp at Ullesthorpe Court. The present tenants are being housed on housing sites throughout the District. As the huts become vacant, they are being disposed of and the site cleared. Five huts remain to be sold.

DILAPIDATED PROPERTIES

The number of houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation was 7. Six of these were closed under Section 10 of the Local Government (Miscellaneous Provisions) Act, 1953, and one house was rendered fit by the owners.

HOUSING ACT, 1949 & 1952

Improvement Grants

The Council continued to receive a number of applications, the majority of which were from owner/occupiers, to carry out improvements to property. They have approved schemes and grants in 11 cases.

HOUSING CONSOLIDATED REGULATIONS, 1925

Article 31

- | | | | |
|----|---|---|----|
| 1. | The number of houses which on inspection were considered to be unfit for human habitation. | = | 51 |
| 2. | The number of houses the defects in which were remedied in consequence of informal action by the Local Authority or their Officers. | = | 46 |

- | | | |
|----|---|-------|
| 3. | The number of representations made to the Local Authority with a view to | |
| | (a) the serving of notices requiring the execution of works or | |
| | (b) the making of demolition or closing orders. | = 7 |
| 4. | The number of notices served requiring the execution of works. | = Nil |
| 5. | The number of houses which were rendered fit after service of formal notices. | = 1 |
| 6. | The number of demolition or closing orders made. | = 7 |
| 7. | The number of houses in respect of which an undertaking was accepted. | = Nil |
| 8. | The number of houses demolished. | = 1 |

WATER SUPPLY

Northern and Eastern Water Supply Scheme

More progress has been made on this section of the District water supply scheme and new 9" and 6" mains have been laid in Welford Road from the Council's boundary at Arnesby to the reservoir at Knaptoft, now in course of construction. In addition, a contract has been let for the laying of a new main from Knaptoft reservoir to Bruntingthorpe Aerodrome at a cost of £2,715, the cost of this main to be defrayed by the Air Ministry.

South Western Area Water Supply Scheme

Several applications for water supplies were received from farms situated adjacent to the Walcote/South Kilworth Road, and a scheme was prepared. On being approved by the Ministry, tenders were accepted in September of this year and the work is now about to start. This made provision for the laying of some 4,000 lineal yards of 4" main.

Water Samples

Thirteen samples of water were taken from public supplies. Of these, 4 were submitted for chemical analysis, 2 of raw water and 2 of treated water, and they all proved satisfactory, as did the 9 samples taken for bacteriological purposes. During the year, 18 samples were taken from well supplies and submitted for bacteriological examination, 11 of these were unsatisfactory, and 7 satisfactory. Where these supplies were unsatisfactory, appropriate action was taken.

MILK & DAIRIES REGULATIONS

During the year, 43 samples of milk were taken for biological purposes, and only one of these proved unsatisfactory.

This sample of milk was from a retailer who sold very little milk, and, after a Stoppage Notice had been served, he decided to cease his retail trade and all the milk was sent in for pasteurisation.

SLAUGHTERHOUSES

When it became known that the Ministry's control of slaughtering would end on the 29th June, a meeting of local traders was called to discuss the requirements of the District and to ascertain the number of slaughterhouses which could be reopened.

As a result of this meeting, and previous inspections, it was found that of the 19 privately owned slaughterhouses licensed in 1938, 14 were suitable for use provided that works were carried out to bring them up to a reasonable standard of suitability and cleanliness.

Schedules of works were sent out to the occupiers concerned, and finally in December there were 10 slaughterhouses in use in the District, and recommendations were made for the re-licensing of these premises.

During the period the 29th June to the 31st December, 1954, the following animals were examined after slaughter:- 1,009.

SEWERAGE & SEWAGE DISPOSAL

The work on the provision of sewage disposal works to serve the villages of Ullesthorpe, Claybrooke Magna and Claybrooke Parva commenced during the year.

The inclement weather in the autumn prevented work being carried out on the disposal works, but the contractors made good progress on the laying of sewers in Claybrooke Magna, and Claybrooke Parva, and work to the value of £8,000 was completed by the end of the year.

SCAVENGING

The Council continued to give a regularly weekly collection of house refuse throughout the District, but the amount of waste to be collected in Lutterworth Town increased beyond the capacity of the wagon employed on this round. The Council, therefore, have purchased a larger vehicle to deal with this refuse.

GENERAL

In addition to these works, regular inspections have been carried out as shown in the table on the opposite page.

	No. of Inspections
Animal Keeping	6
Bakehouses	8
Dairies	32
Drainage Works	143
Dwelling-houses (all purposes)	165
Food Premises	24
Offensive Trades	2
Refuse Collection and Disposal	143
Rodent Control	26
Schools	1
Shops	23
Slaughterhouses and Meat Inspection	172
Smoke Observations	1
Tents, Vans, Sheds, etc.	17
Verminous and Dirty Premises	4
Water Supplies	90
Workshops, outworkers, etc.	21
Other inspections	175
TOTAL	1,052

I am,

Yours obediently,

H.G. MCNAUGHT,

Engineer, Surveyor & Sanitary Inspector.

